Sentinel Physician Enrollment Form

Please fax to the Department of Health (808) 586-8347 ***by September 15, 2002***

2002-03 Influenza Season

Last Name: _____ __MD __DO __RN

First Name: _____

Practice Name: _____

Street Address: _____

Zip Code: _____ State: *HI* Island: _____

Phone: _____ Fax: _____

E-Mail address: _____

Specialty: (check one)

__ Family Practice

__ Internal Medicine

__ Pediatrics

__ Emergency Medicine

__ Other specialty: _____

FREE Journal subscription you would like to receive: (check one)

__ MMWR (morbidity and Mortality Weekly Report)

__ Emerging Infectious Diseases